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WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH - VITAL REGISTRATION OFFICE
PHYSICIAN'S / MEDICAL EXAMINER'S CERTIFICATE OF DEATH
350 CAPITOL STREET, ROOM 165, CHARLESTON, WV 25301

FILED
STATE FILE NUMBER 018985
NOV 8 2018

BULGER, James J.
NAME OF DECEDENT

FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last): James Joseph Bulger Jr.
2. SEX: Male
3. SOCIAL SECURITY NUMBER:
4a. AGE (Last Birthday) (Years): 89
4b. IF UNDER 1 YEAR: Months / Days
4c. IF UNDER 1 DAY: Hours / Minutes
5. DATE OF BIRTH (MM/DD/YYYY): 09/03/1929
6. BIRTHPLACE (City and State or Foreign Country): Boston, MA
7a. RESIDENCE (STATE): MA
7b. COUNTY: Suffolk
7c. CITY OR TOWN: Boston
7d. STREET AND NUMBER: 17 Twomey Court
7e. APT. NO.:
7f. ZIP CODE: 02127
7g. INSIDE CITY LIMITS? ☐ Yes ☒ No
7h. 2nd LEGAL RESIDENCE - PROBATE USE ONLY - OPT.: STREET & NUMBER / APT. NO. / CITY OR TOWN / COUNTY / STATE / ZIP
8. EVER IN US ARMED FORCES? ☒ Yes ☐ No
9. MARITAL STATUS AT TIME OF DEATH: ☐ Married ☐ Married, but separated ☐ Widowed ☐ Divorced ☒ Never Married ☐ Unknown
10. SURVIVING SPOUSE'S NAME (Give name prior to first marriage.)
11. FATHER'S / PARENT 1'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): James Joseph Bulger Sr.
12. MOTHER'S / PARENT 2'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Jane V. McCarty
13a. INFORMANT'S NAME: [redacted]
13b. RELATIONSHIP TO DECEDENT:
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code):
14. PLACE OF DEATH (Check only one: see instructions)
IF DEATH OCCURRED IN A HOSPITAL: ☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival
IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: ☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☒ Other (Specify): Prison
15. FACILITY NAME (If not institution, give street & number): U.S. Penitentiary Hazelton
16. CITY OR TOWN, STATE, AND ZIP CODE: Bruceton Mills, WV 26525
17. COUNTY OF DEATH: Preston
18. METHOD OF DISPOSITION: ☒ Burial ☐ Cremation ☐ Entombment ☐ Donation ☒ Removal from State ☐ Other (Specify):
19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place - location in Box 20.): Saint Josephs Cemetery
20. DISPOSITION LOCATION (City, State): Boston, MA
21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY: Charleston Mortuary Service 1101 Bigley Avenue Charleston, WV 25302
22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH: Dale R. Burger
23. LICENSE NUMBER (Of Licensee):

LICENSED HEALTH PROFESSIONAL OR CORONER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH
24. DATE PRONOUNCED DEAD (MM/DD/YYYY): 10/30/2018
25. TIME PRONOUNCED DEAD: 0904
26. SIGNATURE AND TITLE OF PERSON PRONOUNCING DEATH (Only when pronouncer IS NOT also the certifier.)
27. DATE SIGNED (MM/DD/YYYY)

→ DATE/ TIME OF DEATH MUST BE COMPLETED

TYPE/PRINT IN PERMANENT BLACK INK

PHYSICIAN, QUALIFIED APRN, OR NON-PHYSICIAN CORONER

28. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY): found 10/30/2018
29. ACTUAL OR PRESUMED TIME OF DEATH: found 0821
30. WAS MEDICAL EXAMINER OR CORONER CONTACTED? ☐ No ☒ Yes — IF YES, MEDICAL EXAMINER CASE # 18-6303

CAUSE OF DEATH

31. PART I. Enter the chain of events – diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. Enter only one cause on a line. Add additional lines if necessary.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Blunt Force Injuries of the Head	minutes
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to the cause listed on line a. Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause in PART I.

32a. WAS AN AUTOPSY PERFORMED? ☒ Yes ☐ No
32b. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☒ Yes ☐ No

33. DID TOBACCO USE CONTRIBUTE TO DEATH? ☐ Yes ☐ Probably ☒ No ☐ Unknown
34. IF FEMALE: N/A
☐ Not pregnant within past year
☐ Pregnant at time of death
☐ Not pregnant, but pregnant within 42 days of death
☐ Not pregnant, but pregnant 43 days to 1 year before death
☐ Unknown if pregnant within the last year
35a. CAUSE/MANNER PENDING? ☐ Pending Investigation ☐ Date Amended — See 35b. for Final Manner of Death
35b. FINAL MANNER OF DEATH: ☐ Natural ☐ Accident ☐ Suicide ☒ Homicide ☐ Could not be determined

MEDICAL EXAMINER OR CORONER ONLY

36a. DATE OF INJURY (MM/DD/YYYY): found 10/30/18
36b. TIME OF INJURY: found 0821
36c. PLACE OF INJURY (e.g., Decedent's home, construction site, restaurant, office building, wooded area): Prison Cell - U.S.P. Hazelton
36d. INJURY AT WORK? ☐ Yes ☒ No
36e. LOCATION OF INJURY: Street & Number: 1640 Skyline Drive; Apt No.: ; City or Town: Bruceton Mills, WV 26525; State or Country: ; Zip Code:
36f. DESCRIBE HOW INJURY OCCURRED: Assaulted by other(s)
36g. IF TRANSPORTATION INJURY: ROLE: ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____
SEATBELT RESTRAINT STATUS: ☐ Restrained ☐ No restraint ☐ Unknown
HELMET STATUS: ☐ Helmet ☐ No helmet ☐ Unknown

PHYSICIAN, QUALIFIED APRN, OR CORONER ONLY

37a. CERTIFIER (Check only one):
☐ Certifying Physician or Qualified APRN -To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing & Certifying Physician or Qualified APRN -To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☒ Medical Examiner/Coroner-On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
Signature of Certifier ▶ [signature] Date Certified 10/31/18
37b. PRINT NAME, ADDRESS, AND ZIP CODE OF PERSON CERTIFYING TO CAUSE OF DEATH (Item 31.): Allen Mock, CME, OCME Main Charleston, WV
37c. TITLE OF CERTIFIER: MD

OFFICE USE ONLY

38. FOR OFFICIAL REGISTRAR USE ONLY- SIGNATURE OF REGISTRAR ▶ [signature] Gary L. Thompson
39. FOR OFFICIAL REGISTRAR USE ONLY- DATE FILED: 11/14/2018

STATE/COUNTY ORIGINAL
FORM VS-002
(Rev. 9/2017)